Raising the Bar in Long-Term Care

by Gene Gantt, RRT

It's hard to believe, but up until recently there was very little focus on best practice standards when it came to long-term ventilator care in skilled nursing facilities (SNFs). Patients who were difficult to wean or in need of chronic ventilator care were often housed in SNFs (nursing homes), where there was little or no respiratory therapist involvement. Registered nurses (RNs) were scarce and usually were required to cover entire buildings; and even then, nursing homes were not required to have an RN on duty 24 hours per day. Licensed practical nurses (LPNs) provided the bulk of the patient care; and more often than not, for ventilator patients only very basic ventilation was provided. In fact, the only regulation of record in my home state of Tennessee was that the facility providing ventilator care was required to have a back-up generator outside the building in the event of main power loss.

In 1998, Medicare implemented a completely new system of payment for SNF care. A prospective payment system (PPS) replaced the previous retroactive reimbursement (e.g., do a service/procedure, bill for it, and get paid for it). Essentially, under PPS, payment for patient care was paid up front regardless of what the cost to the facility was for the care of a patient. As a result of the SNF PPS, even those facilities that were providing ventilation care, even suboptimal care, no longer wanted to bring in this population. Ventilator care was not really covered by Medicare, and a patient with a fractured hip was much more financially rewarding than those with a tracheostomy and on a ventilator. Under most state Medicaid programs the extra services and care required for a ventilator patient were not reimbursed at all.

about the author...

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By 2000, the backlog of patients taking up precious space in hospital ICUs reached a breaking point here in Tennessee, as it did across the United States. We were keeping more patients alive, our technology was improving, and the population was aging. Most states responded by creating Medicaid wavier services that would cover home ventilation and in-home nursing services and care. The problem was that this benefit soon got way out of hand due to the large numbers of patients, with each case costing the state up to $500,000 per year.

Setting the standard

In Tennessee, we tried to find a solution by opening a ventilator-specific unit in a wing of an SNF. Instead of suboptimal care, we decided to provide state-of-the-art best practice services (e.g., 24/7 respiratory therapist, portable ventilators, battery back-up, pulmonology consults, and clinical monitoring for safety). We began with eight beds and discovered quickly that the patients we were receiving could still be liberated from the ventilator given the appropriate time and effort. Our unit soon went to 16 beds and was successfully weaning 75% of the ventilator patients referred to us, a rate consistent with various studies in the literature.

It came to mind a few years later that the situation of caring for ventilator-dependent patients — and in a significant number of cases, how to wean the ventilator patient — would only continue to grow; and without best-practice standards, there would be a hodgepodge of care models popping up across the states. In order to protect the patients and develop similarity of care models, an idea took hold that we needed

best-practice standards implemented proactively rather than in response to future situations. With that in mind, a set of nine basic best-practice standards were developed. The question was how to get them recognized by SNFs and insurance payors, including Medicare and Medicaid, and turn these standards into required regulations. Requiring ventilator standards could have been achieved through legislation, but that would take a long time and would be very politicized along the way. Convincing Medicaid officials first was also a daunting task as they have their hands full with many other issues and, although important, this only affected a small group of individuals. So we took another route that worked out very well.

In 2004 a set of nine simple best-practice standards were originally jotted down on a napkin, further refined, and later presented to the Tennessee Society for Respiratory Care Board of Directors for their consideration as recommended best practice. The Tennessee Society agreed and formally recognized the standards and sent them to the Tennessee Respiratory Care Board (TRCB). In the spring of 2005 the standards were endorsed by the TRCB and were posted on the Department of Health website, thus making them "official" in defining the community standard of care. In 2009 the standards were adopted as state government policy requirements in Tennessee for anyone providing ventilator care, and in essence became Tennessee law.

The AARC Position Statement can be downloaded at www.aarc.org/resources/position_statements/delivery_of_services_in_snf.html.

In 2009 at the request of the Long-Term Care (LTC) Section of the AARC, these standards were considered by the AARC Board of Directors for publication as a position statement. In December 2009 they were approved and referred to the Board of Medical Advisors and were approved.

Raising the standard

In 2010 the LTC Section and AARC Director of Regulatory Affairs, Anne Marie Hummel, presented the ventilator standards to the Centers for Medicare and Medicaid (CMS) through the Medicare Agency in Baltimore for future consideration in the conditions of participation for Medicare and Medicaid. Also in 2010, AARC sent every state Medicaid director a copy of the standards and a cover letter urging state Medicaid programs to adopt them under their own state nursing home requirements. Thus far, the Medicaid programs in Florida and Pennsylvania have responded in writing, indicating their agencies intend to adopt the specific additional standards they currently are not requiring already. Georgia Medicaid has adopted them in total, and Maryland Medicaid has reviewed them and plans to adopt them. Several other state Medicaid directors have requested more information. Overall, the response has been very positive; and the outcome is that these best-practice standards jotted down on a napkin back in 2004 have created a new community standard of care that raised the bar significantly in SNFs across the country. By creating the community standard of care, the AARC LTC Section has effectively made these best-practice standards the benchmark in ventilator care in the SNFs.

As we see the number of prolonged ventilator cases rise over the next 10 years, we are hopeful that this effort has made a significant impact in the care for our ventilated population across the United States. ■